Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS419AGC	A. BUILDING _____ B. WING _____	09/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SALVN. ARMY PATHWAYS PROG.	37 WEST OWENS N LAS VEGAS, NV 89030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on September 30, 2008. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility had the following category of classified beds: Category 1 - 42 beds. The facility had the following endorsements: Residential facility which provides care to persons with mental illnesses. The census at the time of the survey was 42. Fifteen resident files were reviewed and twelve employee files were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	Y 000		
Y 070 SS=C	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS419AGC	A. BUILDING _____ B. WING _____	09/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SALVN. ARMY PATHWAYS PROG.	37 WEST OWENS N LAS VEGAS, NV 89030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 070	Continued From page 1 residential facility. This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure 8 hours of training related to providing for the needs of the residents were received annually by 1 of 12 employees. Findings include: Employee #6's (hire date 6/11/02) file did not contain documented evidence of eight hours of annual Caregiver training. The file did contain evidence of five hours of annual Caregiver training. Severity: 1 Scope: 3	Y 070		